ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
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COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Oct. 20, 2021 Case Number: 22-39

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Dr. Jatin Jadhwani

Premise Name: 1st Pet Veterinary Centers (Chandler Location)

Premise Address: 1233 W. Warner Road

City: Chandler State: AZ Zip Code: 85224

Telephone: (480) 732-0018

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Elena Pritchette

Address: [redacted]

City: [redacted] St[redacted] Zip Co[redacted]

Home Telephone: _____ Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: Emma Pritchette

Breed/Species: Pittbull

Age: ~5-7 years old, adopted Sex: Spayed female Color: Blue and white

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Dr. Jatin Jadhwani, 1233 W. Warner Road, Chandler AZ, 85224, PH: (480) 732-0018.

Dr. Kaleigh Robinson, 1233 W. Warner Road, Chandler AZ, 85224, PH: (480) 732-0018.

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Maureen Kirk, DV[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 10.18.2021.

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Emma was seen at 1st Pet Veterinary Centers by Dr. Jadhwani and Dr. Robinson for a severe dog bite wound. She was not stabilized appropriately, her wounds were not assessed and repaired appropriately and on transfer to the overnight doctor (Dr. Robinson) she was neglected and died in her cage and did not receive standard of care by either veterinarian while under their care at 1st Pet Veterinary Centers. Despite being advised to her critical condition and need for stabilization and IV fluids multiple times by my friend Dr. Maureen Kirk, who brought her in and was there with my husband and I during initial presentation.

Arizona State Veterinary Medical Examining Board
1740 W Adams St, Suite 4600
Phoenix, AZ 85007

Dr. Jatin Jadhwani
Narrative regarding case 22-39

To Whom It May Concern:

Emma Pritchette, presented to me at 6:40pm on the evening of 09/28/2021. She was immediately brought back to the treatment area by Dr. Maureen Kirk (Elena Pritchette's friend). Dr. Kirk discussed the case with me and informed me that Emma had been attacked and bitten by another dog and that she had sustained wounds to the right shoulder as well as right axillary region. Dr. Kirk discussed her concerns for the bleeding as well as concern for severe head trauma. On presentation, Emma did have a moderate amount of hemorrhage noted from the wounds on her right forelimb - however the bleeding subsided and eventually stopped after application of manual pressure with the help of gauze padding. On neurological examination, Emma appeared to be mentally appropriate, and was able to ambulate on 3 limbs (noted when she was put on weighing scale). No nystagmus, head tilt or ataxia was noted at this time. The left pupil did appear to be miotic with evidence of scleral hemorrhage, and therefore deemed that the anisocoria was due to ocular trauma and less likely head trauma.

An IV catheter was secured in her right cephalic vein and 0.1 mg/kg of Hydromorphone was administered IV at 6:45pm. Bloodwork was run at this time which showed a mildly elevated lactate at 3.7mmol/L and a mildly elevated Creatinine at 2.1 mg/dl. PCV/TS at this time read as 48% and 6.0. X-rays were also performed which showed "Disruption of soft tissues associated with the cranial/medial aspect of the right shoulder. Soft tissue swelling and soft tissue gas involving the right proximal forelimb, pectoral region and right chest wall. Hypovolemia". No obvious signs of fractures or intrathoracic penetration were observed at this time. A compression bandage was placed around Emma's right forelimb to ensure that bleeding did not resume. I informed Dr. Kirk and the owners (Elena and Keith Pritchette) of these findings and discussed a plan going forward which involved hospitalizing Emma with IV fluids, sedating her in the next few hours to evaluate her wounds and control any obvious sources of bleeding, and also starting her on appropriate antibiotics, pain medications and anti-inflammatories. The owners and Dr. Kirk approved this plan.

An oscillometric blood pressure reading was taken at 7:59pm which read as 95/65 with a MAP of 72 and a 600mls bolus of IV fluid bolus was ordered at that time.
Emma was sternally recumbent in her kennel and resting comfortably, and was alert and responsive. No obvious strikethrough was noted through the compression bandage.

Emma was then sedated at 10:07pm with Dexmedetomidine (0.005mg/kg IV) and Midazolam (0.1mg/kg IV). The decision to choose dexmedetomidine was based on the fact that it is a medication that can be reversed with the use of atimapazole (antisedan), provides analgesia, and reliable sedation.

It was noted that under sedation Emma became hypothermic with a temperature of ~97 F and in response, she was given a 600ml warm LRS bolus over 30 minutes. To begin the procedure, the compression bandage was removed and a small amount of blood (approximately 20-25mls) was noted on the bandage material. The area around the wounds was clipped and cleaned in routine manner by a veterinary technician. A small amount of blood was seen oozing from the wounds. The wounds were evaluated, no obvious signs of active bleeding were noted. The wounds on the lateral aspect of the right forelimb were then debrided in routine manner, the larger wound was closed with surgical staples and the wounds were otherwise left open to allow for drainage, as is the standard of care for dog bite wounds. The wounds on the medial aspect of the right forelimb were also evaluated and only puncture wounds were noted at this time with no obvious signs of active hemorrhage.

Emma was hypothermic after the wound exploration and therefore was maintained on heat support and IV fluids. Sedation was reversed using atimapazole (antisedan). Recovery was uneventful. I called the owners shortly after this and left a voicemail stating that Emma was recovering well from sedation and that we would call with another update in the morning.

Shortly after this call, it was brought to my attention that Emma did develop a mild amount of bleeding from her wounds. She was brought back to the treatment area and the wounds were assessed again, bleeding was once again controlled using pressure and another compression bandage was placed around Emma's right forelimb. At 11:17pm, oscillometric blood pressure was rechecked which was 116/85 with a MAP of 92 (improved since last blood pressure check). Emma was continued on IV fluid therapy at 100ml/kg/day, unasyn at 30mg/kg IV q8h, and carprofen was administered at 2.2mg/kg SQ once. Hydromorphone was to be continued overnight at 0.1mg/kg IV q4-6h.

Emma's case was then transferred to Dr Robinson at 12:35am for overnight care with a plan to continue monitoring serial blood pressures as well as evaluating the bandage for any evidence of bleeding. A recheck PCV/TS was performed, which was 44%/4.4. Since Emma was severely attacked by her housemate and sustained extensive soft tissue trauma, this was not unexpected, but also did not indicate the need for a transfusion at that time.

At 1:21am, Emma was found unresponsive in her kennel by the ICU technician. As I was still present in the ICU at this time, a code was called and the team immediately started closed chest CPR at the kennel, while an endotracheal tube and the crash box containing epinephrine and atropine were obtained by another member of the team. After about 1 minute, Emma was carried to the treatment area, and chest compressions were continued. A 9mm ET tube was secured in place and manual ventilation was initiated. Epinephrine and atropine were administered intravenously and CPR was continued as per RECOVER guidelines. The compression bandage was evaluated and a small amount of blood was noted on the gauze padding (approximately 15-20 mls in total).

I spoke with Keith Pritchette on the phone and informed him that, unfortunately, Emma had coded and that we had begun CPR on her. We discussed continuing CPR for another 15 minutes, following which, if we did not achieve spontaneous circulation, we would stop. Keith Pritchette consented to this.

After continuing CPR for another 15 minutes without success, I again called Keith Pritchette and advised we were unable to revive Emma. Keith Pritchette then gave us permission to stop CPR. I expressed my condolences and asked him if they would like to go over cremation options at this time or in the morning. Mr Pritchette elected to go over these options in the morning. Emma's body was therefore placed as a hold.

The concerns of the complainant are that Emma did not receive appropriate stabilization or wound care. The patient received fluid therapy (a fluid bolus and continuous rate infusion), pain medications (opioids and NSAIDs), broad spectrum antibiotics, an anti-emetic, serial blood work, radiographs, neurologic exam, heat support, ophthalmic exam, serial blood pressure monitoring, and repeated assessment for excessive on-going hemorrhage. Due to the dynamic and traumatic nature of dog bite wounds, initial decontamination, debridement, and exploration are not always definitive. Smaller wounds are often left open to allow for drainage, as not all contaminated material can be removed. Some bite wounds require multiple surgeries. In Emma's case, there did not appear to be any obvious bleeding arteries that were visible under sedation – this was later supported by the fact that the PCV remained >40% even 6 hours after presentation and fluid therapy. The mild bleeding noted was controlled with simple application of pressure and was assumed to be related to extensive soft tissue damage and inflammation.

In closing, I sincerely sympathize with the owners for their loss, and can understand their concerns. However, Emma's unfortunate passing was not due to veterinary care that fell below the standard of care.

Thank you,

Dr Jatin Jadhwani

Douglas A. Ducey
- Governor -

Victoria Whitmore
- Executive Director -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Steven Dow, DVM
Gregg Maura
Justin McCormick, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Marc Harris, Assistant Attorney General

RE: Case: 22-39
Complainant(s): Elena Pritchette
Respondent(s): Jatin Jadhwani, DVM (License: 7330)

SUMMARY:
Complaint Received at Board Office: 10/20/21
Committee Discussion: 3/1/22
Board IIR: 4/20/22

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On September 28, 2021, "Emma," an approximately 5 – 7 year-old female Pitbull was presented to 1st Pet Veterinary Centers on emergency after being attacked by another dog in the home.

The dog was evaluated by Dr. Jadhwani, an IV catheter was placed and pain medications were administered. Diagnostics, including radiographs and blood work, were performed and recommendations for hospitalization were approved. The dog was started on supportive care and compression bandages were placed over some of the bleeding wounds.

Later that evening, the dog was sedated to evaluate the dog bite wounds; some wounds were debrided, some were stapled closed and others were left open to drain. The dog was hypothermic and heat support was provided.

Later the dog's care was transferred to Dr. Robinson for overnight care and monitoring. After evaluation, Dr. Robinson made some adjustments to the treatment plan based on her

findings. A short time later the dog was found unresponsive; CPR was unsuccessful and the dog passed away.

Complainant was noticed and appeared.
Respondent was noticed and appeared with attorney David Stoll.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Elena Pritchette*
- Respondent(s) narrative/medical record: *Jatin Jadhwani, DVM*
- Consulting Veterinarian(s) narrative/medical records: *Maureen Kirk, DVM*

PROPOSED 'FINDINGS of FACT':

1. On September 28, 2021, Complainant called her friend, and veterinarian, Dr. Maureen Kirk and reported her two dogs were in a fight. Dr. Kirk went to the home to evaluate the dog. She noted the dog was non-weight bearing on her right front leg with the paw was dangling; the dog was bleeding from a wound on the right lateral aspect of the shoulder with more hemorrhage noted from an unknown wound somewhere between her right front leg and chest. The area where she had been previously laying was soaked in frank blood.

2. Dr. Kirk advised Complainant that she was concerned with a humeral fracture and severe hemorrhage. She had anisocoria with the right pupil being mydriatic and the left pupil being miotic, scleral hemorrhage on the left eye, blood rostrolaterally to the left pinna and in the left pinna, which were all concerning for head trauma. There were other wounds that Dr. Kirk was unable to fully assess and felt the dog should be taken to an emergency facility immediately. She told Complainant that the dog was in shock and the wounds could be life-threatening; she feared the dog could bleed out.

3. Dr. Kirk took the dog to 1st Pet Veterinary Centers and had Complainant meet her there. On the way, Dr. Kirk called the premises to advise that the dog was coming in and relayed her findings so they would be prepared. Upon arrival, Dr. Kirk spoke with Dr. Jadhwani. She told him that she was the primary veterinarian for the dog and was also a personal friend of the pet owner. Dr. Kirk reported her findings to Dr. Jadhwani and that the dog needed stabilization and diagnostics. After her discussion with Dr. Jadhwani, Dr. Kirk went to the front to complete paperwork; the dog was put under her account and she left a deposit. The account could be transferred into Complainant's name once she arrived.

4. Dr. Jadhwani evaluated the dog; the dog was a weight = 44.1 pounds, no TPR noted. The dog was quiet, shocky; ambulatory on 3 legs, non-weight bearing on right front limb; eyes showed anisocoria, miotic left eye, and scleral hemorrhage; there were 3 puncture wounds on lateral aspect of right shoulder, 2 puncture wounds on media aspect of left shoulder, laceration on side of left ear, multiple small puncture wounds and abrasions on left hindlimb, severe SQ emphysema over the right shoulder and chest. The dog was 5 – 7% dehydrated

and mentation was appropriate. An IV catheter was placed and the dog was administered hydromorphone 0.1mg/kg IV; blood was collected for testing and revealed a mildly elevated lactate at 3.7, a mildly elevated creatinine at 2.1, and a PCV/TS at 48%/6.0.

5. Dr. Kirk stated that once Complainant arrived they were allowed to visit the dog. There was an IV catheter in place – they were told that the dog received pain medication and blood was collected for testing. Staff was preparing to radiograph the dog. No IV fluids had been started.

6. Radiographs revealed disruption of soft tissues associated with the cranial/medial aspect of the right shoulder. Soft tissue swelling and soft tissue gas involving the right proximal forelimb, pectoral region and right chest wall. There were no obvious signs of fractures or intrathoracic penetration were observed at that time. A compression bandage was placed around the dog's right forelimb to ensure that bleeding did not resume. According to Dr. Jadhwani, he informed Dr. Kirk and Complainant of the findings and discussed a plan going forward which involved hospitalizing the dog with IV fluids, sedating her in the next few hours to evaluate the wounds and control any obvious sources of bleeding. The dog would be started on antibiotics, pain medication and anti-inflammatories.

7. According to Dr. Kirk, she and Complainant were updated by Dr. Jadhwani 1-2 hours later. He advised that the dog had a corneal ulcer to the left eye (fluorescein stain revealed no uptake according to the medical records) and did not believe the dog had head trauma. Dr. Jadhwani also went over the blood work and radiographs results. When asked, he stated the dog had been started on fluid resuscitation and an estimate for hospitalization overnight on IV fluids, wound exploration and continued care. The estimate was approved and signed. Dr. Kirk noted at that time, the dog was still not hooked up to IV fluids, she was dysphoric, and had low blood pressure. Dr. Kirk spoke to a colleague and was advised that the dog was in good hands; Dr. Kirk and Complainant left a short time later.

8. Dr. Jadhwani stated that the dog's blood pressure was low therefore 600mLs bolus IV fluids were administered to the dog. The dog remained sternal and rested comfortably in her kennel. There was no obvious strike through on the compression bandage. The dog's fluid rate was 80mL/hr.

9. Around 10:00pm, the dog was sedated with dexmedetomidine and midazolam IV. Dr. Jadhwani stated that he chose that combination based on that it could be reversed with antisedan, it provides analgesia, and was a reliable sedation. Dr. Kirk questioned the use of dexmedetomidine.

10. The dog's wounds were clipped and cleaned. Wounds on the lateral aspect of the right shoulder were debrided, staples were placed over the wound and the distal aspect of the puncture wound was left open to allow for drainage. Two other puncture wounds were left open to drain. On the medial aspect of the right shoulder, the wounds were clipped and

cleaned and left open to allow for drainage – no bleeding noted. The wound of the left ear was cleaned and sutured closed.

11. While under sedation, the dog became hypothermic; post-op vitals revealed T = 96.6, pulse = 130, respiration = 25 and the dog was reversed with antisedan. The dog was administered warm LRS fluids – 600mLs over 30 minutes and maintained on heat support. The dog was also administered Unasyn, Rimadyl and Tobramycin to the left eye. No urine output was documented.

12. Dr. Jadhwani contacted Complainant with an update on the dog. A short time later, the dog had a mild amount of bleeding from her wounds. The wounds were again assessed and the bleeding was controlled with a compression bandage to the dog's right forelimb. The dog's blood pressure had improved; IV fluids were continued at 100mg/kg/day along with the other medications (Unasyn, Rimadyl, Tobramycin and Hydromorphone).

13. Later that evening around 12:35am, the dog's care was transferred to Dr. Robinson. She evaluated the dog and noted a heart rate > 200bpm therefore increased the IV fluid rate to 150mL/hr and administered the dog cerenia. Dr. Robinson stated the dog was depressed but responsive, however since the dexmeditomidine had been reversed, she ordered an additional dose of analgesic medication to address the possibility that the tachycardia was secondary to pain and inflammation. The cerenia was administered to address any possible cause of nausea, which could also cause tachycardia. Dr. Robinson ran a PCV/TP (44%/4.4) to evaluate potential blood loss; the dog was deemed to not need a transfusion. She was considering adding a colloid bolus to the dog's treatment. While Dr. Robinson was creating the flow sheet the dog was found unresponsive. CPR was started immediately.

14. While Dr. Robinson continued resuscitation efforts with technical staff, Dr. Jadhwani contacted the pet owners. He was given permission to discontinue CPR efforts after they were unable to regain spontaneous circulation after 15 minutes of treatment.

15. Dr. Robinson stated that she had staff remove the IV catheter and bandages from the dog's remains. The bandages did not have a significant amount of blood in them – approximately 15mLs in the gauze – and there was not a pool of blood in the kennel, only small smears on the blankets.

16. When Complainant visited the dog, she was told by a male technical staff member that the dog had bled out and was found dead in a pool of blood. Complainant then spoke with Dr. Robinson who advised that the dog likely threw a clot.

17. The dog's remains were taken to Dr. Kirk who performed a preliminary post-mortem exam, then the dog was taken to Midwestern University for a necropsy.

18. On October 1, 2021, Dr. Kirk spoke with Dr. Mumaw, the responsible veterinarian for the

premises, regarding her concerns on how the dog was treated while in their care.

COMMITTEE DISCUSSION:

The Committee discussed that there were a number of issues with the handling of the dog and medical record keeping. Complainant went for urgent care and expertise with respect to the dog's condition. The dog should have had surgery and an explore on the medial side as well as the lateral side, not just a wound care. Closing the wound on the lateral side with staples and not getting the subcutaneous/subcuticular area closed internally was inadequate. Additionally, the amount of fluids the dog received was inadequate and did not treat the shock.

The wounds were closed without placing drains. There was subcutaneous damage to both sides the limb revealed on the radiographs that was not explored. The damage is underneath the skin as is typically for dog bite wounds.

The dog required additionally stabilization prior to sedation and treating the wounds. It would have been best to ensure the dog was stabilized then transfer the dog's care to an associate/surgeon in the morning. The wound care was not necessary at that particular time. The trauma is likely what caused the death of the dog and the outcome may not have been different.

The caseload may have had influence on Respondent's decision.

The Committee had issues with omissions of documentation in medical record with respect to examining the dog prior to sedation/general anesthetic and monitoring the dog while the dog was having surgery.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the Veterinary Practice Act occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (22) Medical incompetence; *failure to stabilize the dog prior to addressing the dog's wounds; inadequately addressing the volume needs of the dog; and inadequately assessing the extent and severity of wounds.*

ARS § 32-2232 (18) *as it relates to* ***AAC R3-11-502 (H) (2)*** *for failure to examine the dog within 6 hours before anesthesia was administered or surgery was performed and document the animal's temperature, heart rate, respiration rate, diagnosis, and general*

condition in the medical record.

***ARS § 32-2232 (18)** as it relates to **AAC R3-11-502 (H) (3)** for failure to record the dog's heart rate and respiratory rate in the medical record immediately after giving the animal a general anesthetic and monitored and recorded a minimum of every 15 minutes while anesthesia is being administered.*

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division

DOUGLAS A. DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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IN ACCORDANCE WITH A.R.S. § 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the April 20, 2022 meeting of the Arizona State Veterinary Medical Examining Board, the Board considered the recommendations of the Investigative Committee regarding case number 22-39 In Re: Jatin Jadhwani, DVM.

The Board considered the Investigative Committee's Findings of Fact and Conclusions of Law:

- ***ARS § 32-2232 (22) Medical incompetence;*** *failure to stabilize the dog prior to addressing the dog's wounds; inadequately addressing the volume needs of the dog; and inadequately assessing the extent and severity of wounds.*

- ***ARS § 32-2232 (18)*** *as it relates to* ***AAC R3-11-502 (H) (2)*** *for failure to examine the dog within 6 hours before anesthesia was administered or surgery was performed and document the animal's temperature, heart rate, respiration rate, diagnosis, and general condition in the medical record.*

- ***ARS § 32-2232 (18)*** *as it relates to* ***AAC R3-11-502 (H) (3)*** *for failure to record the dog's heart rate and respiratory rate in the medical record immediately after giving the animal a general anesthetic and monitored and recorded a minimum of every 15 minutes while anesthesia is being administered.*

Following discussion, the Board concluded that Respondent's conduct did not rise to the level of a violation and voted to dismiss this issue with no violation. Regarding the medical record keeping violations, Respondent submitted materials that showed he was in compliance with the Veterinary Practice Act.

Respectfully submitted this 18TH day of May, 2022.

Arizona State Veterinary Medical Examining Board

Jim Loughead - Chair